Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ARLINGTON ORTHOPEDIC ASC
800 ORTHOPEDIC WAY
ARLINGTON TX 76015

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
INDEMNITY INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-11-3122-01

MFDR Date Received
MAY 13, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The authorization under Cert # 27277762 was first approved for date range begin 06/04/10 and end 10/05/10. However, we requested and was granted an extension for this authorization to end 07/20/2010 by sandy per phone conversation on 06/25/10""

Amount in Dispute: $910.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor in this matter contends that they received a verbal authorization forf the treatment in dispute. However, Respondent has no record of this alleged authorization. Thus, the treatment was denied for lack of preauthorization. No reimbursement is owed."

Response Submitted by: Downs♦Stanford, PC, 2001 Bryan St., Ste. 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 6, 2010 through July 19, 2010	Physical Therapy Services	$910.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

- 015 – Description no available.
- 663 – Reimbursement has been calculated according to the state fee schedule.
- 18 – Duplicate claim/service.
- 247 – A payment or denial has ready been recommended for this service.
- W1 – Workers Compensation State Fee Schedule adjustment.
- 197 – Precertification/authorization/notification absent.
- 881-015 – Payment denied/reduced for absence of precertification/authorization.

Issues

1. Did the requestor submit a copy of the medical bill?
2. Did the requestor obtain preauthorization for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(A), requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration…" Review of the documentation submitted by the requestor finds that the request does not include a copy of the medical bill(s) as submitted to the carrier for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A).
2. 28 Texas Administrative Code §134.600(f) requires that "concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the carrier by telephone, facsimile, or electronic transmission..." Review of the documentation submitted by the requestor finds that the request does not include any documentation to verify the request for concurrent review was made. The Division concludes that the requestor has not met the requirements of §134.600(f).

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 19, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.